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Viana, Alba Jean Batista; Sousa, Eduardo Sérgio Soares; Neves, Ednalva Maciel

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RESEARCH

Racismo nos serviços de saúde: a ausência do cuidado com as mulheres negras vítimas de violência sexual

Racism in health services: a lack of care of violence against black women victims of sexual violence

Racismo en los servicios de salud: la falta de atención a las mujeres negras víctimas de violencia sexual

Alba Jean Batista Viana[1], Eduardo Sérgio Soares Sousa[2], Ednalva Maciel Neves[3]

ABSTRACT

Objective: to analyze the access and the use of health practices given to 40 women in a situation of sexual violence in a public health service of reference in the State Paraiba, Brazil. **Method:** It is a descriptive documentary study with a quantitative and qualitative approach, performed in a public service of the State of Paraíba reference to assistance to women in situations of sexual violence. **Results:** in 39% of cases the higher frequency of aggressions predominated in women of low-income social class, between 10-20 years of age, and 20% of them were pregnant at the time of the agression. Most of the victims were black women (72%). The type of sexual violence more employee was the rape (59%). Besides the delay to start the service, the exams for AIDS prophylaxis and emergency contraception, in 69% of notifications were not recorded. **Conclusion:** these aspects reveal the racism and the precarious conditions of health for black women, suggesting a possible non-valuation by health professionals, similar of what occurs in other social spaces in our society. **Descriptors:** sexual violence, racial inequality, health care, social and human rights.

RESUMO

Objetivo: analisar o acesso e a utilização das práticas de saúde prestada a 40 mulheres em situação de violência sexual em um serviço público de saúde de referência na Paraíba. **Método:** estudo documental descritivo, com abordagem quantitativa e qualitativa, realizado em um serviço público do Estado da Paraíba de referência para assistência às mulheres em situação de violência sexual. **Resultados:** em 39% dos casos a frequência maior das agressões predominou nas mulheres de classe social de baixa renda, entre 10 - 20 anos e 20% se encontravam grávidas no momento da agressão. As maiores vítimas foram mulheres negras (72%). O tipo de violência sexual mais empregado foi o estupro (59%). Além da demora em iniciar o atendimento e realizar exames, a profilaxia AIDS e anticoncepção de emergência, em 69% das notificações não foram registradas. **Conclusão:** Estes aspectos revelam o racismo e as precárias condições de saúde das mulheres negras, sugerindo uma possível não valorização por parte dos profissionais, semelhante ao que ocorre em outros espaços sociais na nossa sociedade. **Descritores:** violência sexual; desigualdades étnico-raciais; atenção à saúde; direitos humanos e sociais.

RESUMEN

Objetivo: analizar el acceso y la utilización de las prácticas de salud prestada a 40 mujeres en situación de violencia sexual en un servicio público de salud de referencia en Paraíba. **Método:** un estudio documental descriptiva con un enfoque cuantitativo y cualitativo, realizado en un servicio público del Estado de Paraíba referencia a la asistencia a las mujeres en situación de violencia sexual. **Resultados:** en los 39% de los casos la frecuencia mayor de las agresiones predominó en las mujeres de clase social de baja renta, entre 10 - 20 años y las 20% se encontraban embarazadas en el momento de la agresión. La mayoría de las víctimas fueron las mujeres negras (72%). El tipo de violencia sexual más empleado fue el estupro (59%). Además del retraso para iniciar el atendimiento y realizar exámenes, la profilaxis de la SIDA y anticoncepción de emergencia, en los 69% de las notificaciones no son registradas. **Conclusión:** Estos aspectos revelan el racismo y las precarias condiciones de salud a las mujeres negras, sugiriendo una posible no valoración por la parte de los profesionales, semejante al que ocurre en otros espacios sociales en nuestra sociedad. **Descriptores:** violencia sexual; desigualdades étnicas raciales; atención a la salud; derechos humanos y sociales.

[1]Master of Nutritional Sciences, with specialization in public health, Doctoral student of the Postgraduate Program in Sociology at the Federal University of Paraiba (UFPB). Email: albajean2009@gmail.com. [2]Doctor in Sociology, Adjunct Professor IV of the Federal University of Paraiba (UFPB), is teaching at the Department of Obstetrics and Gynecology and the Postgraduate Program in Sociology. Email: esergiosousa@uol.com.br. [3]Doctorate in Anthropology, Associate Professor I of the Federal University of Paraiba (UFPB), is teaching at the Department of Social Sciences and the Postgraduate Program in Anthropology. Email:ednneves@gmail.com.

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INTRODUCTION

This article analyzes the relationship between gender-based violence against black women and health care. From the reflections of several authors regarding the theme, we seek to play the ethnic-racial stratification in access and health care for women in situations of sexual violence. The objective is to make an argument that places the ethnic and racial aspect not as a mere obstacle to women's access and use of support services, but understand it as an integral element of health care.

The approach given the text is related to the information collected from a health care service from the service records, which allowed to draw a profile of the women attending the service and care practices carried out by health professionals. The recorded information revealed which enabled think the violence suffered and the quality of care offered.

Sexual violence against women is understood here as the action or conduct that occurs in the control and subordination of sexuality and the female body, through the imposition of another's desire, which is incorporated as constitutive rules that regulate the practice sexual[1]. This concept reveals the woman's consent and no loss of autonomous exercise of her sexuality. The consent becomes an important issue, as can be inferred about the moral character of the victim.

The consensus is that the whole of violence practiced against women, sexual violence takes on a different meaning, because of the act with consequences for these women, considering physical damage, psychological and moral resulting from domination, coercion and force of inequalities and gender. Violence can thus express themselves in any age group, reaching women from different social conditions, races, ethnicities, cultures and societies. And it stands out as a kind of aggression that reaches the most individual and reserved part of being human, which is your sexuality, limiting or canceling the exercise of human, sexual and reproductive rights[2].

However, when considering the criterion of race/color, the vast majority are black women, so that there is no denying that these women are exposed to a greater burden of violence - the ethnic/racial. It is known that a social group is not established by race or color relationships, but racial and ethnic differences are associated with social inequalities. The race itself is not a risk factor, but the adverse social situation of a racial/ethnic group is that it is in a vulnerable feature[3]. To Brito[4], "racial discrimination aggravates the reality frame of black women, making them extremely vulnerable to all forms of violence and deprivation".

In designing of Ianni[5], it was during slavery that formed a powerful racist culture. So that racial prejudice is an instrument of domination, which added to the class prejudice, produces discrimination, intolerance, access to social rights inequalities, political, legal and cultural, moreover, violence in its many forms of manifestations. Therefore, this

author argues that race and social class are made simultaneously and vice versa in the dynamics of social relations, ie the games of social forces.

In societies in general, discrimination becomes a means of distinction, a kind of universal law, according to which certain population groups are deprived of social equality, political and economic.

In this regard, we endorse the position of Madeira[6], to proclaim that:

> The ethnic aspect constitutes a fundamental variable to define the social, economic and political position that these women occupy. Black women suffer doubly by both gender and ethnic condition, and the slave tradition continues legitimizing forms of violence, the use of such practices with impunity tolerated women like thing. At present this is in the form of tourism and sexual abuse, prostitution and marginalization. Such practices are encouraged by the stereotypes that stigmatize black women as: sexually available with overexcitement and ugly and poor, hot, warm and sensual. Sexual violence against black women, like in the colonial period, continues romanticized, it re-issues in the social imaginary acquiring new clothing.[6:1]

According to Munanga[7], those conditions were established from the moment that Brazil slave inherited his patriarchal structure of the family of Portugal, which led to the black woman situations of vulnerability in the social space. Because, due to the existing demographic imbalance between the sexes during the period of slavery, many black slaves became easy victims of all kinds of aggression, especially sexual by the white masters, as a consequence, a large part of these women were transformed in prostitutes in order to ensure means of income and be prevented from establishing any stable family structure.

The practice of sexual violence against black women marks the national historiography. Gilberto Freire[8] in the book "Great Masters and the Slaves", portrays the role of black women in slavery period, where it served as labor and sexual object for you and your children, the black woman being victimized countless of a system of economy, family and patriarchy, the subdued silence on violence. in this context, while the white woman was guarded and watched, the black woman was subjected to sexual abuse, rape and humiliation.

> Originally, the mulatto was the product of rape of African women by the Portuguese and not the result of a traditionally consecrated marriage [...]. Since the existence of the mulatto means the product of the prior rape of the African women, the implication is that, after the brutal rape, the mulatto woman became only fornication object, while the black woman continued denied its original function, ie the compulsory labor [...]. Although regarded as ethnic bridge between black and white, the mulatto does not enjoy a different social status from the black. If during slavery mulattos were able to receive some privileged treatment in relation to blacks, today they are, in their majority from the poor class and thus constitutes the biggest victim of racial discrimination, because of the ambiguity color / class, as well as being more numerous than blacks[7].

In this confluence that is given under the baton of the Portuguese, disparate racial arrays, distinct cultural traditions and outdated social formations, they face each other and merge to make way for a new people, a new corporate structure model. Again, because "(...) appears as a national ethnicity, culturally differentiated from their forming dies, Latina strongly, spurred by a syncretic culture and singularized the redefinition of cultural traits derived from it"[9:19].

In this corporate structure model, the black has been routinely denied their womanhood by racism and sexism. From the racism and the resulting constructed hierarchy, being black will become an inferior position while sexism acts in disqualification of women, ie, gender, hindering their integration in institutional spaces, as well as their political representation and its possibilities social climbing. Such difficulties would be generated by ethnocentrism and patriarchy that block the self-determination of social and political subjects. The struggle for greater autonomy involves the politicization of the body, in which reverberate numerous claims and social and political changes, including better health[10,11].

Currently, Brazil has the second largest black population in the world, concentrating around 50% self-rated African descent (black or mixed). However, social indicators indicate that this population is at a disadvantage throughout the country, which can be evidenced from the socioeconomic conditions and access to health services, which not only limit their welfare level, but also of future generations[12].

With regard to health, we note that despite the progress made in the last decades, there is still a gap in the understanding of racial differences in access to services. The results presented by Simon and colleagues[13] revealed that access to health enshrined as a universal right has not been guaranteed to the whole population, a fact that undermines the promotion, protection and recovery of health universally.

The epidemiological profile of the black population is marked by singularities, in particular the living conditions that generate differences in the health-disease. The findings of Santos[10] and Brazil[14] on ethnicity and gender, showed the continuity of social inequality, given that in 2004 the percentage of black women who have not had access to gynecological examination was 10% higher than the number of white women; those who did not have access to breast clinical examination are 27% higher than white women. In the period 2000-2004, the HIV/AIDS infection increased from 36% to 42,4% among black women, while the white female population, the incidence decreased. Black women have less access to anesthesia during childbirth and surgical sterilization; have a lower life expectancy compared white women and 58% of black youth deaths from external causes refer to murders, showing the existence of racial inequalities in health.

These conditions put black women in an inferior position that socially marginalize, from better working conditions, access to education, to decent health care, among others, and which influences negatively on the valuation of culture and the recognition of their self-image, leading them to internalize this devaluation against white, a factor that contributes to decreased self-esteem[9].

Thus, the scenario presented reaffirms the most vulnerable of the black population in access and utilization of health services, demonstrating the need for public policies more effective health, promoting affirmative action and overcoming the historical differences found between the white population and black.

The Brazilian Federal Constitution, by introducing health as a right of all and duty of the State, takes responsibility for ensuring universal and equal access to actions and health services, in order to include the needs and demands of the population. In this context, attention to women in situations of sexual violence is part of public health policies and fall in full perspective, quality and resolution of attention to realization of the Unified Health System (SUS). However, although it is an undeniable advance as a right of citizenship, it is

not when it comes to state duty, once again, that this is not assured everyone the same quality of health care, either from a regional point of view and / or ethical-racial, subjecting black women to occupy unequal places in social networks and bring along unequal experiences of birth, life, illness and death[15,16].

With regard to access and utilization of health care services for black women, most of the difficulties are not the result of their genetic characteristics, but their socioeconomic conditions, educational and historical inequalities related to poverty and charged by racism. The institutionalization of the health policy of the black population demanded the inclusion of racial framework National Health Plan and requires an understanding of the need cutouts for the establishment of priorities and the identification of gaps in Brazilian health policy. Thus, the actions that will have the greatest impact on the health of the black population are those aimed at improving social and health conditions, reducing mortality and morbidity rates, facilitating access to health services for care, improving these services and paying assistance that embraces and respects diversity, to ensure the promotion of racial equality in health[17].

For Fernandes[18] the Brazilian pattern of social relationship, still dominant, was built by a slave society to keep the subordinate black to white. So while this pattern of social relationship is not abolished, economic inequality, social and political between blacks and whites remain large, although this situation is not recognized publicly and explicitly.

METHOD

It is a descriptive documentary study with a quantitative and qualitative approach, performed in a public service of the State of Paraíba reference to assistance to women in situations of sexual violence. The characterization of the sample was obtained from forty protocols of care, selected at the Medical Archive Service by manual collection, with information that characterized the socio demographic profile, the act of violence and assistance to the victim.

These documents constitute the study sample for meeting the inclusion criteria: being records of women of any age group, met within five days of the aggression and contain notification of sexual violence on the period selected for the study. Analyses were excluded from the charts that the existence of sexual violence was discarded, because it is a consensual sexual relationship without the presence or threat of violence.

In the search for demographic and social characteristics, we raise the following variables of users: age; occupation; color; marital status; place of residence; city of origin; type suffered sexual violence; the aggressors; the use by the abuser of substances that induce behavioral disorders; location / time of the occurrence; time between aggression suffered and care in the health service, and; test ordering of the Technical Standard protocol adopted by the Ministry of Health. The data collection period took place from January 2006 to June 2007.

With regard to qualitative data to analyze the information collected in the compulsory notification forms and records, we adopted the content analysis technique to

obtain, through systematic and objective procedures, the design of the contents relevant structures. After analysis, we contemplate the proposed objectives in the study, making up the inferences and intersections information needed for this purpose. As regards the figures, the analyses were performed by applying the simple percentage of tests and frequency distribution, using the Epi-Info, version 6.01.

The standards were followed for research involving human beings, established by Resolution 196/96 of the National Health Council, as approved by the Ethics Committee and authorization of the institution in order to meet all ethical procedures required to study.

RESULTS AND DISCUSSION

From the total of the services rendered, the main victims of sexual violence were to black women (color brown and black skin) with 72% of notifications in relation to white women (28%). For Lopes[15], despite the Brazilian society does not live with racial prejudice and segregation legally or explicitly, "*assigning a negative social significance to certain phenotypes of diversity justify the unequal treatment, and imposes merges barriers that prevent or hinder the black social mobility* ", so that the naturalization of racism and sexism systematically reproduces stereotypes and stigmas about black women, causing losses to the statement of his racial identity and social value. These data refer to studies of Brazil[14] with racial / ethnic groups, points out that when the vast majority of calls to the black population from violent causes, are the result of social inequalities and issues related to gender violence and racism.

When taken into account the social conditions, the frequency of attacks predominated among black women of low income. This result corroborates to the findings of the Reference Center, Studies and Actions about Children and Adolescents – CECRIA[19], to show that violence is usually materialized against people who are physically, emotionally and socially disadvantaged as a result of relationships built so uneven. Therefore, we consider that the poverty conditions are favorable for black women from becoming most at risk of sexual exploitation and other violations of their rights.

According to Fry[20], in Brazil racial discrimination and social inequality between whites and blacks are most often arising from the heritage left by slavery and the black of the difficulty to adapt to the capitalist system. In this sense, Stedile and Santos[21] point out that these factors shape a political and economic structure that provides modes of exploitation, marginalization, and racist and sexist poverty.

According to Oliveira et al[22], this type of violence affects all social classes and in different historical moments, however, is in the lower classes it becomes public because of complaints. For in the higher strata of society the silence pact has not yet been overcome, violence remains veiled, remain anonymous and purchase the discretion through private care when they do.

With regard to age and occupation, the study showed that most victims concentrated in the age group between 10 and 20 years (39%) and designated as students (52,5%), considered one stage of life greater fragility and vulnerability to this type of violence in the social space. The age group reveals the vulnerability of the black female population for

violent injuries, both in terms of defense capabilities, as in the social and living conditions of affected women.

According to Ribeiro, Ferriani and Reis[23], the fact of the victims are socially regarded individuals in psychological development and morally immature, be awakening to sexuality and femininity, it is taken in the context of violence as a form of "provocation" to the aggressor that appeals to sexual abuse. In this context, the attackers reinforce a power view of the female.

Regarding the occurrence of sexual violence sites, it was found that most of the records showed lack of data on the subject (35%); followed by roads (27,5%) and households (22,5%). As for the time of occurrence of the attacks, most cases does not display this information in the protocols (77%) and identified cases followed the night between 19 and 23 hours (23%). In the case of marital status, most of the reports this finding was not expressed in the medical records (52%), predominantly aggression among single women (32%).

The geographical distribution of the occurrences of aggression reinforces a lack of profile of the victims, on the outskirts and in poor areas with poor access to basic services. The combined ratio of the local analysis/schedule of aggression/marital status of victims suggests that the prevalence of violence in single women, can be justified because of the greater constancy of the attacks have occurred in women at an early age and are more exposed to leisure activities during the night.

Another aspect to be considered worrying is that the residence had the second highest number of cases. In this sense, according to the Map of Violence (2012), the reported cases of violence against women, 71,8% of incidents succeeded domestically and his attackers were his teammates and former teammates. These results corroborate the study Ribeiro, Ferriani and Reis[23], in stating that in the home the limits imposed by privacy isolate the victim from the eyes and ears public, giving attackers a favorable location for the offense is committed without witnesses or covered by the complicit silence, which reveals itself as an element that reinforces the underreporting of sexual violence.

Regarding the type of sexual violence, the most used was rape (59%). In this category of analysis 28% of cases showed no record of this information in the protocol. The type of sexual exposure, most of the reports was not identified explanation of this figure (45%). Next, the highlight was the vaginal type as the most practiced (40%). The attackers were male (90%) and were known to the victims (52,5%).

As stated Cruz and Oliveira[25], the colonial rape committed by white men against black women, today is perpetuated and leads in other situations of violence against black women, sex tourism and trafficking in women, in addition to violence psychological, sexual abuse and deprivation. With regard to sex tourism, most of the women involved are black and 60% of these women have between 13 and 16 years. So, to Santos[10], sexual violence against black women is not only considered the contemporary phenomenon, but also as something rooted history of the constitution of humanity. The abolition of slavery without planning, as well as the society of patriarchal and sexist base, led to the African-descendent women today become double prejudiced against the racial and gender.

The data regarding the types of sexual violence, we observed that these are in agreement with the literature. However, when considering the identification of the offender to the age of the victims (10-20 years) stand out as the known perpetrators of

aggression, demonstrating controversies with the literature, given that most studies shows that in adolescent and adult, usually the perpetrators are unknown, as claimed by Lopes et al[26].

In all the cases analyzed there are reports of women that the perpetrator used any drugs during the occurrence of aggression (10%) and that the sexual crime was committed by a single perpetrator (75%). Regarding the use of drugs during the episode of aggression, the results refer to Grossin studies, Sibille, Lorin, Banasr, Brion, Durigon[27] and Brazil[28] who reported that cases of violence seen in health services 14% and 26%, respectively, suspected use of alcohol or illicit drugs by offenders at the time of sexual crime. However, we note that this data has been little explored in the literature.

With regard to the time elapsed between the aggression and the service, we found that most of the records do not indicate that information about registration (40%), soon after, stood out: after 72 hours (35%) and before 72 hours (25%). As for the request tests for prophylaxis of STD/AIDS and emergency contraception, predominates absence of notifications in the medical records regarding these procedures (69%); then distinguished themselves the required tests for VDRL, HIV and Hepatitis B (22%); HIV and hepatitis B (3%); VDRL and HIV serology (3%) and HIV serology (3%). The STD/AIDS prophylaxis and emergency contraception were administered in 28% and 3% of cases respectively.

According to Pfeiffer and Salvagni[29] it is important to assess the risks involved in each case and the need for prophylaxis against hepatitis B, drug protection against non-viral STDs, chemoprophylaxis for infection with human immunodeficiency virus (HIV) and emergency contraception. This stage of care is crucial to protect the victim from damage and disorders of sexual violence; it should be implemented within 72 hours since the assault.

The study shows that despite the Technical Guidelines have been adopted by the Ministry of Health since 1999 and the implementation thereof in this referral service have given in 2006, the data presented show a negligible percentage of the use of this protocol to prevent contamination by STD/AIDS and unwanted pregnancy, considering that the sample contingent 28% of the notifications made prophylaxis with Kit STD/AIDS (non-viral and anti-retroviral DST) and only 3% of cases emergency contraception was instituted, whose motive most likely it was the top time at 72 hours between the attack and the service.

Noteworthy is also the high percentage of non-fulfillment of items related to civil status, residence and place of occurrence of the crime, suggesting a possible no valuation of these data by health professionals who carried out the visits to the victims. These findings refer to Vicente studies and Vieira[30], by highlighting that these professionals may find it difficult to question the woman about the act of violence perpetrated, either unprepared or fear of offending her. And the feelings of frustration and impotence concerning the resolution of the situation can also cause difficulties in properly a subject, as well as the interaction with the patient, particularly when considering the time of Miniature reality for the service. These authors also point out that despite the increase in social awareness regarding gender violence, there is still limits the ability of health professionals to recognize and deal with this problem.

CONCLUSION

Despite the struggle for social recognition and legal principles in defense of ethnic and racial equity, cases of sexual violence against black women do not cease to exist, and neither are seen evenly by society as a crime. We observed through critical analysis of Brazilian history, that the conditions of slavery, colonization, patriarchy and exclusion have shaped a reality and crystallized structures that are inadequately understood as legitimate. So, even with the efforts in recent decades, this racial group has perpetuated the margins of society, where human and citizenship rights have been neglected.

Racial inequalities resulting from the effects of social exclusion and racism are manifested through practice of prejudice and discrimination. According Messias[3:14] the fact of being black woman "carries a great particularity, to add to their social, emotional, economic, political, cultural and emotional, racism factor, which outlines relations in both the public as in private".

The inequality between whites and blacks is discrepant in all aspects, from access to social ascent to the use of quality health services, equal and respectful racial diversity. From this perspective, it is a majority without access to essential goods and services, and exposed to violence in our society.

Social rights are provided for in our Constitution and in international documents such as treaties and conventions. In SUS, universality assumes that all Brazilians have equal access to health services and their actions without any barrier of legal, economic, physical or cultural. However, in everyday life the right to health is not exercised equally by all people. This is due to the existing social inequalities in the structure of our society.

Studies show that despite the assistance to women in situations of sexual violence be part of public policy, services just answer the pressing needs of the victims, ie the actions are timely, fragmented, without continuity of commitment at attention. We found that the health professional subdues addressing sexual violence to biomedical knowledge, disjointed the biopsychosocial context. In this sense, when the complaints are psychological and social order, the structural barriers between women care network prevents the necessary assistance flow.

When taken into consideration the ethical-racial perspective, we denote the discussion attention black women victims of sexual violence for the health sector is a major paradox. This is the ethnic-racial dilemma of providing care from the break with socially defined values and perceptions. Confronted with this paradox, in order to guarantee women of African descent the right to health and autonomy over their bodies demand a continuous and integrated effort of different sectors of society.

Although violence against women is recognized as a public health problem in Brazil, it was not included racial ethnic clipping the reflections. The ethnic-racial inequalities have proved persistent and require actions and public policies to change adversity situation experienced by the black population. However, for these policies to become effective, they must be horizontal, responding to local demands and meet the challenge of involving

society as deconstruction of discourses that maintain and reproduce inequalities between individuals. Thus, combating and eradication of ethical and racial inequalities they become a major challenge for public policy, making it essential that they point an overhaul of practices rooted in Brazilian society, that address the needs, promoting the right to equality of portions of the population falling into the exclusive way in the country.

The comments in this article point out the ethnic and racial disparities existent in health care for black women in situations of sexual violence, in order to contribute to understanding of the subject more broadly, broaden discussions about the theme, serve as inputs for search equity and help all those working with women victimized by sexual violence to act more cautiously, friendly and conscientious.

Importantly, that to facing sexual and racial violence demand understanding that without demolishing the cultural patterns that sustain it we will limit ourselves to take care of the consequences of sexual violence, which is the hallmark of survivors. Therefore, it is essential to continue the struggle for rights and improvements in living conditions of Brazilian black women; the recognition of violence as something unnatural, so we can one day envision a country with less violence and fewer inequalities between men and women, between races and genders.

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Contact of the corresponding author:
Eduardo Sérgio Soares Sousa
João Pessoa - PB – Brasil
Email: esergiosousa@uol.com.br